North Simcoe Muskoka **LHIN**

HEALTHY PEOPLE. EXCELLENT CARE. ONE SYSTEM.

North Simcoe Muskoka Local Health Integration Network
Integrated Health Service Plan 2013 - 2016

Ontario
Local Health Integration Network

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Photograph courtesy of Chigamik Community Health Centre

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Residents and health service providers across the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) place a high value on their health care system. Acutely aware of its importance and need to be responsive to people in their local communities, there is a mutually held belief that health care service delivery is best understood from the perspective of those receiving care.

This common understanding permeates through the NSM LHIN's **Integrated Health Service Plan (IHSP) 2013 – 2016 |** *Healthy People. Excellent Care. One System.*, which outlines NSM's strategic priorities over the next three years. So too does it form the basis of *Care Connections - Partnering for Healthy Communities*, the ten-year operational roadmap designed to bring about the vision of an integrated health system across the NSM LHIN.

Through *Care Connections*, health system partners and communities from across the region have come together committed to the implementation of effective, collaborative strategies designed to improve service delivery and contribute to the needs and well-being of those we serve. As a result, the health system across NSM has come a long way since IHSP 2010 - 2013, in large part due to the implementation of *Care Connections* which remains at the heart of IHSP 2013 – 2016.

The NSM LHIN and its Board of Directors would like to offer sincere thanks and gratitude to all of our health system partners who, with common purpose, have taken ownership and accountability for change and, through hard work, dedication, commitment and collaboration, have brought a bold vision to life.

Equally important is a sincere appreciation for the countless residents who continue to be engaged in the process of bringing health care closer to home. You play an integral role in the development of your health care system and it could not be done without you!

leadership message

Committed to long-term sustainable change, that is to say a new way of thinking, acting and behaving, the NSM LHIN Leadership Council, Board of Directors and staff team are mindful that in a very real sense we have only just begun; that we have so much more to do on the road ahead. As system-wide transformation continues, there is an inherent importance to bringing about long-term, lasting, sustainable change across the NSM LHIN's five local geographic areas.

To this end, there must be a reaffirmation and recommitment to our basic tenets including a collective will to change, a focus on what we can control, careful attention to the changing landscape, open and honest dialogue, the courage to take risk, an awareness of organizational readiness and capacity and a realization that our relationships are very much interdependent.

There is no turning back... no winding down... no stopping now. The residents and health system partners across NSM have come too far in pursuit of building lasting, sustainable and meaningful change. We all have a role to play in the success of our health system; in pursuit of a common and collective vision...

Healthy People. Excellent Care. One System.

Jill Tettmann
CEO, NSM LHIN

Robert Morton
Chair, NSM LHIN Board of Directors

section 1 | introduction

The NSM LHIN is pleased to release its Integrated Health Service Plan (IHSP) 2013 – 2016: *Healthy People. Excellent Care. One System.*

Since the release of its first IHSP 2007- 2010, the NSM LHIN has come a long way in a relatively short (6 years) period of time. A constant, has always been the need to remain flexible and adaptable in order to meet the demands of an ever-changing landscape; which begs the question of how to plan for the future?

Environmental scans *(Appendix A - NSM LHIN and Appendix B – Provincial)* and a Planning Framework *(Appendix C)* played an important part in the development of this IHSP. In particular, environmental scans offered key characteristics of health and healthcare - population breakdown, presence and prevalence of health issues etc. What follows is an informed snapshot of the NSM LHIN landscape which helped to inform and guide meaningful discussions when planning the future priorities and activities outlined in IHSP 2013 – 2016.

Photograph courtesy of Muskoka Seniors

Healthy People

In 2011, the NSM LHIN was home to 461,700 residents or 3.5% of Ontario's population. This population is projected to rise by 35.6% to 630,000 in 2031. By 2016, the population is projected to increase by 7.8%; just over 36,000 people. By 2021, the population is further projected to increase by almost 17%, far surpassing the Ontario average of 13%.

In 2011, 15.9% of NSM seniors were 65 years of age and over; up from 14.7% in 2006. By 2016, NSM seniors will account for 18.3% of the population; 20.6% by 2021. The number of seniors aged 65 years and over is expected to more than double over the next 20 years, from 75,284 in 2011 to 164,257 or 26.2% of the population by 2031.

Within the NSM LHIN, ischemic heart disease, cancers of the lung, colon, colorectal, along with diabetes are the leading causes of death. The top ten leading causes of death account for 57% of deaths. Mortality rates for many health issues including influenza, pneumonia and diabetes, and rates of Potential Years of Lost Life (PYLL) for many issues such as cirrhosis and other liver diseases, intentional self-harm and diabetes are among the highest in the province.

461,700
NSM POPULATION | 2011

630,000
NSM PROJECTED POPULATION | 2031

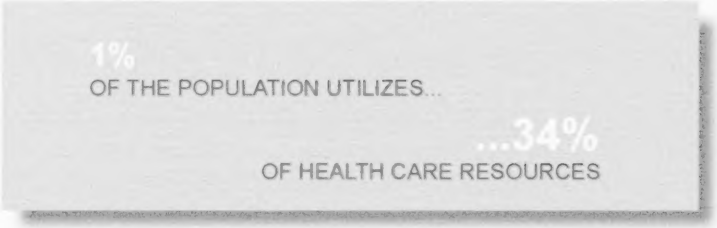
Excellent Care

The population of the NSM LHIN is growing and aging quickly. There is also a clear picture related to causes of mortality and those areas where preventative medicine and primary care can play a leading role toward the provision of the right care, at the right time and in the right place. IHSP 2013 – 2016 takes into account the diversity and

locations of the population in respect of what services to prioritize and where to deliver them.

Care Connections guides the NSM LHIN in support of IHSP 2013 – 2016. As a result, existing projects will be reviewed with an eye to validation, then completion. Building capacity within communities, to care for individuals as close to home as possible and ensure care is delivered in the appropriate location at the right time, will be top-of-mind. Specific attention will be given to the 1% of the population that utilizes 34% of health care resources.

Through the implementation of effective data management and eHealth initiatives (electronic / technology), the integration of information and technology will continue to be a catalyst for "one source of truth."



As we continue to meet the complex needs of an ever-changing population, we must effectively manage our Health Human Resources to support meaningful change including volunteer and caregiver strategies and supports, standardized job profiling so as to meet the needs of community-based care and continued awareness of system capacity.

One System

Care Connections is built around one simple but important premise, that local health care is best designed, implemented and evaluated by those that utilize, deliver and access its programs and services. From this perspective, residents across NSM and health system partners alike share a common belief in both the importance of the

health care system and its responsiveness to the needs of people in their local communities;

> that together, with everyone taking responsibility for their role in the health care system, a truly integrated system can be achieved.

To this end, the structure supporting *Care Connections* is a shared leadership and responsibility model that fosters effective collaboration and, ultimately, accountability for improved outcomes from all of NSM's partners. In collaboration with its health system partners and local communities, the NSM LHIN is actively involved, engaged and participating in planning, implementing and making decisions for the future sustainability of the local health system.

section 2 | Ontario's action plan for health care; a summary

The Provincial Context

Established in 2005, LHINs are mandated to manage the planning, integration, performance and funding of the health system across Ontario. As crown agencies that work in partnership with the Ministry of Health and Long-Term Care (MOHLTC), LHINs provide leadership and accountability for the health system at the local level, ensuring the health needs of people are being identified, coordinated and addressed in a truly integrated system. It is by design that LHINs strategically plan in such fashion as to align with ministerial and government priorities.

Ontario's LHINs are responsible for the allocation of approximately half ($22 billion in 2011) of provincial health care expenditures[1]. Together with the MOHLTC, they align local and regional plans with provincial priorities in order to both improve access to care and ensure long-term sustainability of the health system.

Between April 2003 and March 2012 health sector funding in the provincial budget increased at an average annual rate of 6.1%, for a total increase of $17.9 billion. With a need to curtail growing expenditures, if only to ensure the future sustainability of the health system, the government has indicated that...

> ... funding for the health care system cannot continue to grow at past rates[2]

If access to services and quality care are to be maintained and/or improved upon, such a position will necessitate better value for money from all parts of the health care system.

Of note, Ontario's population is aging. As people age they require more health care; usually, more complex health care. This population of older Ontarians is expected to increase by 43% over the next ten years; twice as many over the next twenty[3].

> If steps to change the way health care is delivered in Ontario are not taken now, it is anticipated that the changing landscape will result in an annual increase, on average, of
>
> **$24 billion/year**
>
> **TWENTY YEARS FROM NOW[4]**

Aligned with ministry efforts, Ontario's LHINs are planning for changes to the health care system that enable...

> ...delivery of the right care, in the right place and at the right time, promote value for the dollar and ensure resources are used in such a manner as to promote sustainability.

Ontario's LHINs are uniquely positioned to address fiscal, demographic and technological challenges, in part through the development of local plans such as this IHSP. In order to provide broad support for the implementation of priorities, a number of additional important factors are also currently aligned with the MOHLTC[5].

They include:

- a shared commitment among providers, administrators and frontline staff to ensure the system is ready for the challenges of the future;
- embracing technologies that provide the new productivity tools and diagnostic techniques that support efficient ways of managing information; and
- using evidence-based practice and research to guide how resources are used, where they are most effectively used and how they best serve patient needs.

Provincial Priorities, LHIN System Imperatives & The NSM LHIN IHSP

Ontario's Action Plan for Health Care is focused on three main areas:

Keep Ontario Healthy
Faster Access and a Stronger Link to Family Health Care
Right Care. Right Time. Right Place.

Provincial LHIN System Imperatives and NSM's vision - *Healthy People. Excellent Care. One System.* - align with the areas of focus in *Ontario's Action Plan for Health Care* (Figure 2.1 and Table 2.1). Of note, System Imperatives guide decisions regarding the allocation of resources to providers and the programs and projects that need to be funded locally.

The NSM LHIN will work in partnership with the ministry, health service providers and residents across the region to ensure a sustainable health system that delivers high-quality, person-centred healthcare for current and future generations.

Keep Ontario Healthy

Keeping Ontario healthy is about supporting and promoting those

habits and lifestyle choices that keep people healthy. In addition to tackling childhood obesity, smoking and cancer screening the province will continue to work on better management of chronic condi-tions such as diabetes. LHINs across Ontario have been working with local providers on chronic disease prevention and management strategies for many years and a strong foundation from which to build upon is in place. There have been many measurable accomplishments improving the way diabetes patients are treated by increasing the coordination of care and adding new resources for individuals and families.

Faster Access and a Stronger Link to Family Health Care

For most people, family health care is the focal point of the health system. When someone needs help, unless it is an emergency, the family physician and/or primary care team is usually the first point of contact with the health care system. Outside of the hospital, it is also where follow-up care is provided and referrals are made to more specialized professionals.

Ontario's Action Plan identifies faster access to primary care, more ways to access family health care resources (i.e., telemedicine points of contact), and the introduction of quality measures to family health care as key components of a fully integrated system. The goals are to ensure appropriate care from family care providers, deliver right care in the right place at the right time and help reduce hospital readmissions.

Enhanced access supports the appropriate use of hospital and clinic resources. Guided by Ontario's Action Plan proposal to bring the planning and accountability of primary care under the mandate of the LHIN's, this IHSP outlines the planning for this outcome includ-ing how LHIN's will measure success and how planned changes will have an impact on quality, person-centred care.

The reduction of hospital readmissions will have an important and significant effect on system sustainability.

In 2008/09, the rate for unplanned readmissions to hospital was 15% in Ontario, a rate MOHLTC considers high compared to other jurisdictions[6]. Working in partnership with local providers, LHINs can help to more fully integrate the health system and, in so doing, develop ways to manage planning and accountability for the full journey of the individual.

The system leadership imperative – *Leading with Quality and Safety by Implementing Evidence-Based Practice*, supports consistent coordinated responses to high-priority quality and safety issues in the system. By reducing adverse events in all care settings (e.g., hospital, long-term care, community/home) Ontario's LHINs can build on the many person-centred safety initiatives currently in practice by health service providers.

In partnership with Health Quality Ontario (HQO) and other key stakeholders, LHINs will work to develop coordinated plans to reduce adverse incidents that impact the quality of care and embrace best evidence-based decision making.

Leading with Quality & Safety
Enhancing Access to Primary Care
System Imperatives
Enhancing Coordination & Transitions of Care for Targeted Populations
Holding the Gains

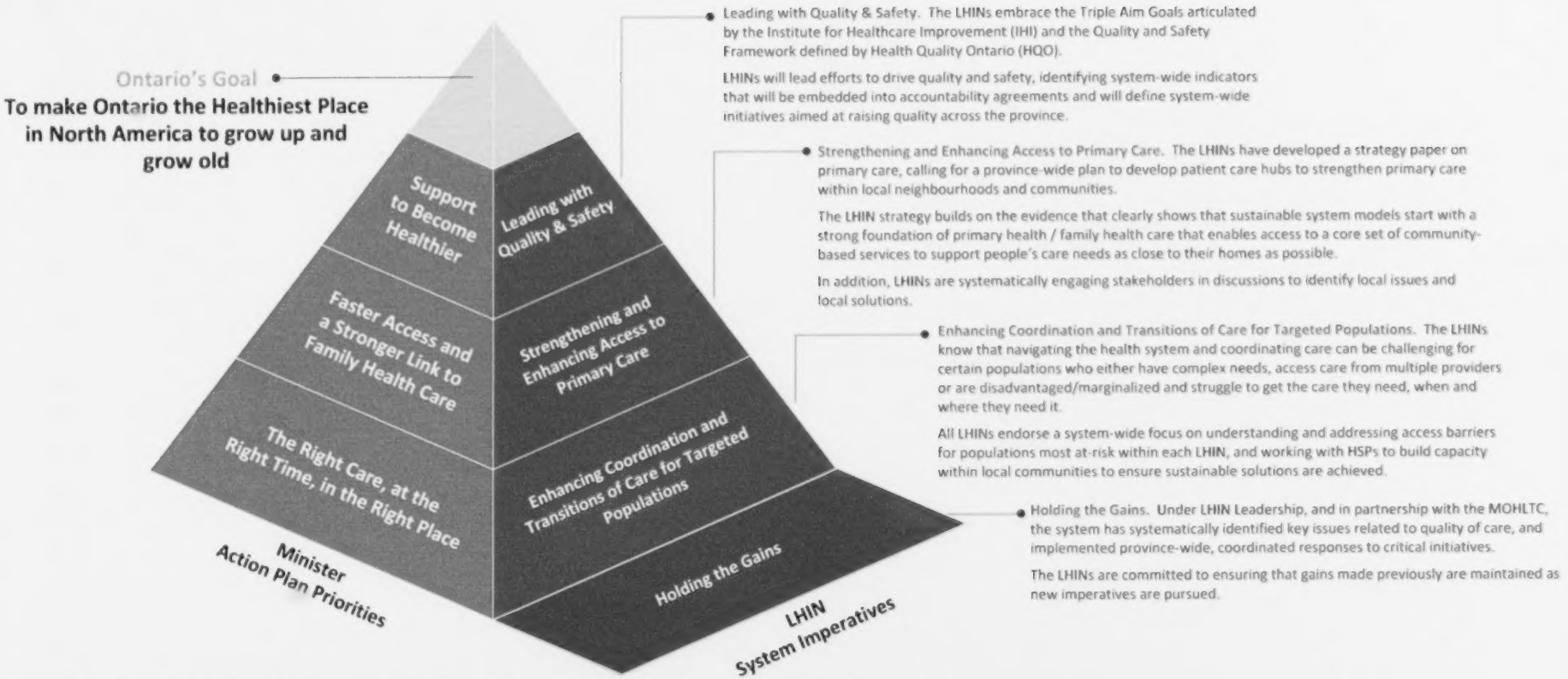

Ontario's Goal
To make Ontario the Healthiest Place in North America to grow up and grow old
Support to Become Healthier
Faster Access and a Stronger Link to Family Health Care
The Right Care, at the Right Time, in the Right Place
Minister Action Plan Priorities
Leading with Quality & Safety
Strengthening and Enhancing Access to Primary Care
Enhancing Coordination and Transitions of Care for Targeted Populations
Holding the Gains
LHIN System Imperatives
Leading with Quality & Safety. The LHINs embrace the Triple Aim Goals articulated by the Institute for Healthcare Improvement (IHI) and the Quality and Safety Framework defined by Health Quality Ontario (HQO).
LHINs will lead efforts to drive quality and safety, identifying system-wide indicators that will be embedded into accountability agreements and will define system-wide initiatives aimed at raising quality across the province.
Strengthening and Enhancing Access to Primary Care. The LHINs have developed a strategy paper on primary care, calling for a province-wide plan to develop patient care hubs to strengthen primary care within local neighbourhoods and communities.
The LHIN strategy builds on the evidence that clearly shows that sustainable system models start with a strong foundation of primary health / family health care that enables access to a core set of community-based services to support people's care needs as close to their homes as possible.
In addition, LHINs are systematically engaging stakeholders in discussions to identify local issues and local solutions.
Enhancing Coordination and Transitions of Care for Targeted Populations. The LHINs know that navigating the health system and coordinating care can be challenging for certain populations who either have complex needs, access care from multiple providers or are disadvantaged/marginalized and struggle to get the care they need, when and where they need it.
All LHINs endorse a system-wide focus on understanding and addressing access barriers for populations most at-risk within each LHIN, and working with HSPs to build capacity within local communities to ensure sustainable solutions are achieved.
Holding the Gains. Under LHIN Leadership, and in partnership with the MOHLTC, the system has systematically identified key issues related to quality of care, and implemented province-wide, coordinated responses to critical initiatives.
The LHINs are committed to ensuring that gains made previously are maintained as new imperatives are pursued.

Figure 2.1: LHIN-Wide System Imperative Model | Linking Provincial Goals to LHIN System Imperatives

Ontario's Action Plan for Health Care	Ontario's 14 LHINs System Imperatives	NSM LHIN IHSP 2013 - 2016	HOLDING THE GAINS	Alignment
Keep Ontario Healthy Support to Become Healthier	Leading with quality and safety	Healthy People Excellent Care One System		YES
Faster Access and a Stronger Link to Family Healthcare	Strengthening and enhancing access to primary care			YES
Right Care. Right Time. Right Place.	Enhancing coordination and transitions of care for targeted populations			YES

Table 2.1: Alignment

Right Care. Right Time. Right Place.

Working with HQO, the province and LHINs will translate evidence into tools and guidelines used to help providers put person-centred and evidence-based care into practice.

As such, **Right Care** is defined as being...

> ...informed by what scientific evidence and clinical guidelines have determined is best for individual person-centred care, eliminating unnecessary procedures and tests, and making resources available for those who need them the most.

The **Right Time** is about...

> ...having better access to the type of care needed.

This could mean telemedicine or supports that allow a person to stay at home longer or in the community close to family and friends. This priority also means a renewed emphasis on preventative and proactive care i.e., managing chronic conditions by reducing the number of hospitalizations a person will require, which eases the strain in emergency rooms and inpatient beds across the province.

The **Right Place** addresses several serious health system issues. Notably, is the challenge of Alternate Level of Care (ALC) patients who are in hospital beds and would otherwise be better cared for in the community, with support services to help maintain and improve their quality of life.

> Community care costs a fraction of what it costs to keep a person in hospital. To support the Action Plan's goal of providing more community-based care for seniors, the 2012 provincial budget increases funding for home and community services by four percent annually over the next three years[7].

This allocation will necessitate changes to the funding formulas for traditional health service providers. And, to further support and enable people-centered care, funding formulae for hospitals in particular will require adaptation. LHINs will work with hospital and community partners to transition procedures out of the high cost hospital setting into non-profit community-based clinics.

Furthermore, hospitals' base-budgets will be transitioned into a person-centred funding model where the provider is rewarded for high-quality care and better use of resources. LHINs will continue to work with hospitals through phased implementation of these changes, which began in April 2012. To help address the fiscal concerns of the province, hospital base-budgets have been frozen and there will only be a 2 per cent increase in funding for certain activity-based initiatives such as targeted wait-times reductions and priority treatments.

Photograph courtesy of
Orillia Soldiers' Memorial Hospital

Building on the successes achieved through *Aging at Home, Ontario's Seniors Strategy* includes a renewed focus on keeping people from being unnecessarily admitted to hospital. The expansion of community-based care and the call to empower LHINs to shift resources to where the need is greatest is based on local needs and plans developed throughout this IHSP.

LHINs also have a mandate under this plan to further integrate the health care system, which will enable Ontario residents to navigate care easier and access the programs and services in a seamless manner. Enabling Coordination and Transitions of Care is a LHIN system imperative that focuses on key populations of "high-needs" patients and those at risk of becoming "high-needs" patients. The health care system will provide coordinated plans of care for these targeted populations to assist them in getting the right care when and where they need it.

As outlined in Figure 2.1 and Table 2.1, three pan-LHIN System Imperatives easily coordinate with the Action Plan's three priorities, providing local guidance for the provincial vision. LHINs must be sure to protect the many advances they have made in improving wait-times, value for money, transparency and accountability. As a result, a fourth LHIN-system imperative - Holding the Gains, will help Ontario's LHINs make sound choices about local projects by ensuring that achievements made to date are not lost as new priorities are identified and actioned.

section 3 | NSM's vision for local health system

Vision

It is not by chance but by design NSM's vision, *Healthy People. Excellent Care. One System.*, has been chosen as the title for IHSP 2013 – 2016. It is the foundation upon which *Care Connections* has been designed and identifies the common vision health system

Health System Transformation in the NSM LHIN
Health Sytem Transformation Model

partners across the region are committed to achieving.

Healthy People

Residents across NSM will live healthy active lifestyles and make informed safe choices to promote wellness of their mind, body and spirit in order to be free from injury, pain or illness.

Impacting the health status of an individual is a host of determinants including lifestyle, economic situation, social conditions, employment, access to health services and cultural background. Guided by an understanding of the health status of its population the NSM LHIN, through the implementation of *Care Connections*, will focus on and design health services and programs to meet their specific health and wellness needs.

Excellent Care

Residents across NSM will receive the best quality of person-centred care, based on an appropriate level of care designed to meet the need, and by accessing the appropriate services and programs in the right location and at the right time.

Person-centred care is accessible, equitable and integrated; to the end it meets the need(s) of the person requiring care. The experience of a person in the health system is benchmarked against the requirement to receive excellent care - the right care, in the right place, at the right time.

One System

Residents across NSM will benefit from the collaboration of people with lived experience and partners across the continuum of care, who are dedicated to transforming the system into one that is responsive to the needs of the person; delivered and implemented in an efficient and sustainable manner and supported by the appropriate level of resources.

Mission

Together Achieving...
Better Health. Better Care. Better Value.

If North Simcoe Muskoka's vision is the "why" and the implementation of *Care Connections* is the "how", then NSM's mission represents what health system partners are working to acheive.

Ontarians value and identify with principles that underlie our public health care system. Health service providers and residents across NSM are no different. There is a shared belief in the importance of the health system and its responsiveness to the needs of people in local communities. Health system partners and communities across the region are committed to working collaboratively to develop and implement effective strategies that improve service delivery and contribute to the well-being of those we serve.

Care Connections is the ten-year operational roadmap designed to bring about the vision of an integrated health system across the NSM LHIN. Working within its framework, health system partners and communities across the region are committed to the development and implementation of effective, collaborative strategies, designed to improve service delivery and contribute to the needs and well-being of those we serve.

In the NSM LHIN, it is recognized that transformation of the health system is the shared responsibility of many partners across the continuum of care including residents, people with lived experiences, their families and health care professionals.

> Through *Care Connections*, everyone takes ownership of their health system.

Over the next three years, the *Care Connections* "twelve areas of focus" will remain the priority. Recommendations and deliverables put forward by the twelve Coordinating Councils, each responsible for an area of focus, represent priorities for change.

Collaboration with health system partners, to share accountability and take collective ownership for health system transformation, is already leading to:

Members of the NSM LHIN Behavioural Support Services Team

Healthy People = **Better Health** | improved health of the population: quality person-centred care that meets local needs.

Excellent Care = Better Care | better experiences for the individual: care is accessible, well-coordinated and sustainable.

One System = **Better Value** | efficient operation/sustainability: local health care dollars spent wisely and appropriately.

By staying the course, gains that have been achieved over the first two years of implementation will be sustained.

Values

Be Real. Be Revolutionary. Be Courageous.

NSM's values inspire a new culture that supports continuous improvement and learning. Engaging with purpose, modeling the way and exploring the possibilities are the behaviours required to support change while striving for a collective vision.

Care Connections makes a bold prediction: by working together, we can make the local health system work better. This means coordinating services, managing information and ensuring people move effortlessly from one level of appropriate care to the next in a timely fashion. It will require transforming an "old system" into a "new system": an old system that fostered duplication, waste and inefficiencies, to a new system that is sensible, sustainable, and coordinated effectively to meet the health needs of its residents. To accomplish this transformation the NSM LHIN has adopted *Kotter's Eight Steps for Managing Change* (Figure 3.1).

With *Care Connections* entering its third year of implementation, considerable effort and commitment to create the conditions for change have been made and the introduction of new practices and achievements have been realized (Section 4) and celebrated. As NSM continues to strive toward its vision, IHSP 2013 – 2016 places a focus on Steps 7 and 8. To this end, over the next three years, there is a strong commitment not to let up and to maintain and build on successes and achievements to date, and to make it stick.

Care Connections Twelve Areas of Focus

COMPLEX & CHRONIC HEALTH NEEDS

IN HOME & COMMUNITY CAPACITY

MATERNAL, NEWBORN, CHILD & YOUTH HEALTH

MEDICINE

MENTAL HEALTH & ADDICTIONS

SURGERY

****

COMMUNICATIONS & COMMUNITY ENGAGEMENT

eHEALTH

GOVERNANCE

INTEGRATED HEALTH HUMAN RESOURCES

SYSTEM NAVIGATION

TRANSPORTATION

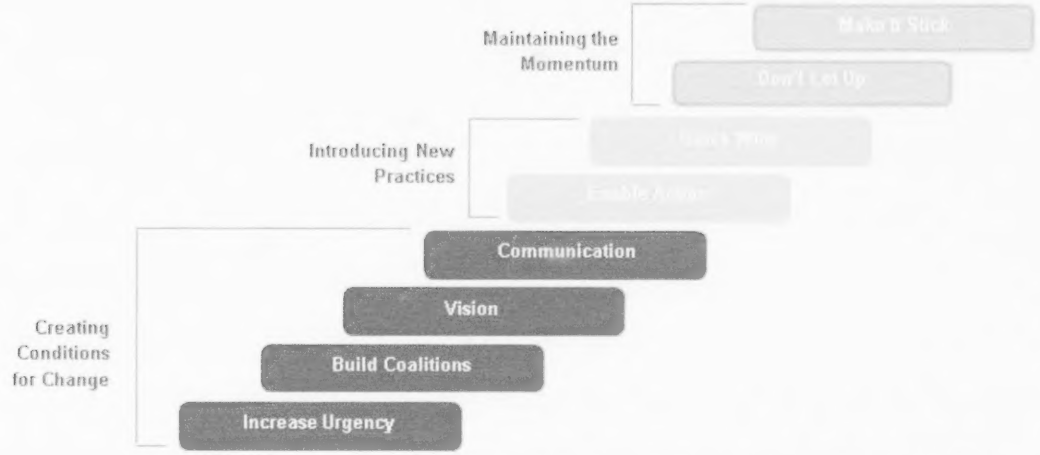


Figure 3.1: Kotter's Eight Steps for Managing Change

section 4 | current local health system and achievements to date

Health system partners across NSM are to be recognized for the invaluable time, effort and commitment they have demonstrated as it relates to transforming the health system across the region. Re-designing a system of care to meet the needs of individuals and families is both exciting and gratifying. Being empowered to design a system based on when, where and how care needs to be delivered grounds the work in creativity and innovation.

Since the implementation of *Care Connections*, the resilience and capacity of health system partners at the system-wide level to deal with and effectively manage change through continuous improvement, is a foundation upon which future change and opportunities will be realized.

Celebrating and rewarding system-wide improvements have not gone unnoticed during this period. Health system partners have seen the positive impacts and results that stem from an environment and culture grounded in collaborative practice and celebration.

The reality of health system partners taking ownership, accepting accountability and managing transformation across the NSM LHIN is, in and of itself, a notable success that warrants celebration. It is a

process that demanded courageous conversations and collaborative innovation. Remaining committed to a common vision, the health of NSM's population is being enhanced through better care, better health and better value.

Achievements made through the members of each of the twelve Coordinating Councils and the corresponding Project Steering Committees have demonstrated ownership to make improvements that are aligned with the vision.

The Integrated Health System Design (IHSD) report in 2010 outlined 231 recommendations to transform the system over the ten-year timeframe. Figure 4.1 amd Table 4.1 outline progress and notable system achievements to date.

Photograph courtesy of:
Royal Victoria Regional Health Centre

Making an IMPACT

Within the first two years of implementing the *Care Connections* ten-year plan, Coordinating Councils have made a notable impact. Of the **231 recommendations** outlined in the Integrated Health System Design (IHSD) report 2010, **17 have been completed** and **102 have been initiated** and are well on their way to completion.

Specifically over the lifespan of the *Care Connections* ten-year plan...

In year one (2011):

6 to be completed | 4 have been completed | 2 in progress

In the first three years (2011 - 2013):

83 to be completed | 10 have been completed | 50 in progress

Between year's four and six (2014 - 2016):

103 to be completed | 3 have been completed | 41 in progress

In the final phase (2017 - 2020):

39 to be completed | | 9 in progress

231	17	102
Recommendations	**Complete**	**In Progress**

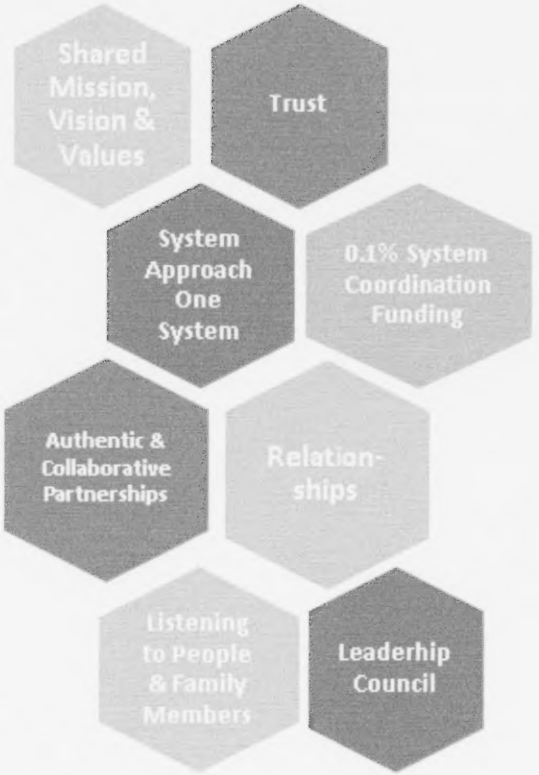
Figure 4.1: Recommendations Update - (IHSD) Report 2010

ON	**Keeping Ontario Healthy**	**Faster Access and a Stronger Link to Family Health Care**	**Right Care. Right Time. Right Place**
LHINs	**Leading with quality and safety**	**Strengthening and enhancing access to primary care**	**Enhancing coordination and transitions of care for targeted populations**
NSM System Achievements	**Vision for Health System in North Simcoe Muskoka** HEALTHY PEOPLE. EXCELLENT CARE. ONE SYSTEM.		
	Analyzed maternal newborn and child needs to focus on maternal mental health, developmental services and standardization in service delivery across the acute settings.	Developed a common assessment tool, satisfaction survey and online bed registry for all patients at the three hospital sites delivering complex continuing care services.	Completed a North Simcoe Muskoka Palliative Care Strategy for system redesign.
	The North Simcoe Muskoka Diabetes website expanded to include self-management education and information for providers (1st in province)	Outlined barriers to long-term care utilization, restrictions to eligibility and/or access for community support sector and opportunities to integrate identification of high-risk patients and discharge planning for those individuals requiring alternative care.	Redesigned the system to support people living with responsive behaviours with over 50 long-term care home & mobile support team staff trained, 100% of new staff hired and 70 organizations actively engaged as liaisons.
	Implemented the new Assisted Living Policy for seniors that have high risk needs.	Completed a memorandum of understanding agreement with Southlake Regional Health Centre for Percutaneous Coronary Intervention (PCI).	Through a successful integration, 11 schedule 1 adult mental health beds moved from Waypoint Mental Health Care Centre to Royal Victoria Regional Health Centre.
	Care "Connectors" in North Simcoe Muskoka work diligently to link unattached patients to available physicians or nurse practitioners to receive access to primary health care.	Developed LHIN-wide emergency department standard order sets for treatment of sepsis, and established medical directives for children's gastro & asthma, acute pain management and back board spine clearing with emergency medical services.	Completed an environmental scan of orthopaedic services and determined a three-site model to best meet the needs of patients and partners. Developed a web-based orthopedic central patient fracture registry and tracking tool for effective flow of patients and prioritize surgical access based on quality care targets.
	Identified other relevant transportation providers to link with and collaborate on key activities and focus areas e.g., Ministry of Transportation – County of Simcoe Transportation Study.	Hospital Report Manager pilot project completed to allow text-based out-patient hospital reports to be downloaded into family physician's Electronic Medical Record within 30 minutes of generation.	LHIN-wide communication tools, tactics and/or strategies in practice on a daily basis for knowledge exchange and sharing, by Communicators across North Simcoe Muskoka.

Table 4.1: Achievements | A snapshot of achievements has been highlighted to demonstrate how, through collaborative change efforts, the vision of *Healthy People. Excellent Care. One System.* is coming alive across NSM.

Following two years of *Care Connections* implementation, the NSM LHIN Leadership Council was able to validate that success achieved to date and the momentum to transform the system is tangible, which supports the commitment to remain focused going forward. To establish a valid direction for the next three years i.e., IHSP 2013 – 2016, health system partners reflected on...

*"What have been the **enabling** factors for the early success achieved through the implementation of the ten-year Care Connections plan?"*



*"What has **impeded** our early success and identify opportunities for continued growth, improvement and change in order to achieve the vision?"*

The process of reflection has allowed the NSM LHIN Leadership Council an opportunity to not only realize the successes achieved to date, but identify areas of success that need to be leveraged over the course of IHSP 2013 – 2016 in order to realize the NSM LHIN vision of *Healthy People. Excellent Care. One System.*

The shifting landscape and changing environment necessitates the current local health system to be nimble, adaptable and ready to embrace change to support the vision. There are many new and exciting opportunities that will be realized over the next three years, the likes of which are only now beginning to align and support health system transformation in NSM. By being open, receptive and focused, these new and existing areas to lever success will intersect with the established culture, structure, and strategy of the *Care Connections* framework.

Healthy People

1% of the NSM Population

Those individuals living with complex and chronic health conditions require the appropriate level of care, in the right location at the right time. The individual's needs span across the continuum of care, yet because of the complexity of their health care needs, their interaction with the health care system is ongoing and longer lengths of stay can be required.

In North Simcoe Muskoka...

1,400 residents fall in the top **1%** of the population utilizing...

$169 million/yr. or 34%
in health care costs.

Due to the high level of need for complex care, the costs associated with delivering the care appropriately at the local level does increase.

As Ontario's Action Plan indicated, 1% of the population accounts for 34% of health care spending; 10%, accounts for nearly 80% of the overall spending.

The average cost of care for an individual living with complex needs (top 1%) in North Simcoe Muskoka is $123,000 annually. This cost is the second highest in the province, next to the Toronto Central LHIN. The population that has the highest complexity of need in NSM are those individuals between the ages of 18 – 44 years of age.

As we plan for an integrated health system that will be sustainable in the future, in order to meet the complex needs of the growing population and be adaptable to the evolving environment, collaboration amongst the health system partners will be crucial as new and innovative models of service delivery are developed to enhance a truly person-centred health system.

People with Lived Experience

The health status of the local population is impacted by many determinants of health, the impacts of which are best felt, told and understood by the individuals and families who have experienced care. Knowing that local health care is best planned, coordinated and integrated by those that live in North Simcoe Muskoka, these experiences are critical to affecting change in such a manner as to make the health system better.

> The implementation of *Care Connections* is centred on the needs and experiences of people / clients / residents as the core of the health system.

As such, the voices of the people are being heard and residents across the NSM LHIN are continuously afforded opportunities to participate. Many are becoming actively engaged as members of the *Care Connections* Coordinating Councils - unpaid stakeholders

such as volunteers, informal caregivers and people with lived experience. There have been and continue to be many unique opportunities to engage people; ensuring a person-centred approach to NSM's health system transformation.

What began in 2006 with the engagement of more than 5000 individuals has grown each year. At the 2012 *Care Connections* Forum the day's proceedings were focused on listening and gaining perspective from those individuals or groups that have had interactions with the health system.

Not only were residents able to attend and participate in workshops facilitated by external health care professionals, the main plenary session was a panel comprised of people with lived experience sharing first hand their unique and compelling stories with over 300 health care professionals.

In addition, partnerships have transpired between organizations and the NSM LHIN to better engage people with lived experience and volunteer caregivers. The information gathered from these

Photograph courtesy of
Chigamik Community Health Centre

partnerships is being shared broadly with health system partners involved in *Care Connections*, helping them to better understand the individual experience and identify opportunities to improve system design and planning.

Aboriginal Peoples

The Local Health System Integration Act (LHSIA) clearly holds the LHINs accountable to *"focus on…Aboriginal people as a priority population"* within health system transformation;

> "The continued involvement and engagement of the NSM LHINs Aboriginal Peoples in regard to the implementation of *Care Connections* is essential for traditional practices and the unique cultural needs of this population to be incorporated and addressed."
>
> *- Local Health System Integration Act*

The improvement of Aboriginal health services is achieved through ongoing collaboration and dialogue with the local Aboriginal Health Circle (AHC) and Aboriginal Peoples as engaged members of *Care Connections* councils and project steering committees.

Moving forward, information gleaned from the Aboriginal Health Circle Symposium 2012, which identified the needs and health requirements of Aboriginal Peoples, will also prove to be an invaluable baseline of knowledge. Addressing equitable 'access' and 'accessibility' to culturally appropriate, sensitive and safe services are the areas of focus from which the planning, development and implementation of an integrated health system will occur.

Health, Wellness and Health Equity

Being proactive by looking upstream at wellness, care equity and health promotion is a means to achieving the vision for Healthy People.

> Understanding the needs and health status of the population being served encourages a continued focus on keeping people well and healthy, in addition to prevention from disease and illness.

Health system planning across the *Care Connections* areas of focus will address the diversity of the population living in North Simcoe Muskoka.

A focus on health equity is to understand how health programs and services need to be delivered in a manner which meets the unique needs of our population. It ensures equitable access to high quality health care for vulnerable and marginalized populations, the Francophone population, First Nation, Métis and Inuit populations and other populations of interest.

As planning and implementation continue Health, Wellness and Health Equity will be a lens to look through as new models of care are developed, thus ensuring better health of the population.

Primary Care

Primary care and access to it, is a major element of establishing a healthy population. Access to a variety of health service providers where and when the individual needs the service, is a determinant of an individual's health. Many doors permit access to primary care including home, urgent care clinics, family physician offices, family-health teams / networks, nurse practitioner led clinics, public health units, in-and-out-patient hospital services, community health centres, walk-in or after hours clinics, long-term care, Aboriginal health access centres, emergency departments, etc.

Over the term of IHSP 2013 – 2016 primary care providers, municipalities and both community and social service providers across the NSM LHIN will continue to engage in open dialogue on how best to improve and sustain coordination of planning, design, performance management and accountability for sustainable primary health care models. The linkage of planning for primary care and healthy communities will be embedded within the *Care Connections* structure

and a priority as system transformation continues.

Health Quality Ontario's new *bestPATH* initiative (Person-centred, Appropriate, Timely Health Care) is a framework designed to guide the development of a high quality, coordinated care experience for individuals with complex chronic illness.

Local primary care partners, along with the NSM LHIN will work in partnership to support the Ministry's focus on transitions-in-care, effective chronic disease management and patient independence and safety for those with chronic illness; all of which are aligned with *Ontario's Action Plan for Health Care* and *Care Connections*.

Health Links

Ontario is improving local health care for seniors and people with complex conditions through the creation of *Health Links*. *Health Links* will bring together all health service providers in a community in order to better and more quickly coordinate local health care services for people who need them the most. Too often, individuals with high-needs receive uncoordinated care as they go from one health provider to another - including their family doctor, specialists, hospitals, home care, long-term care and community supports.

Health Links will help health service providers stay connected every time an individual accesses health care, resulting in a better understanding of the person's needs and what services they need to get better. For residents, this new approach will mean that they get faster access to the right care by not having to answer the same questions every time they need care, getting the right medications, and experiencing smoother transitions between health care providers. They will feel well cared for by a tightly-knit team of providers who are looking out for their well-being.

Health Links will measure results and develop plans to improve access to family / primary care for seniors and people with complex conditions; reduce avoidable emergency room visits; reduce unnecessary re-admission to hospitals shortly after discharge;

reduce time for referral from primary care doctor to specialist appointment; and improve the person's experience during their journey through the health care system.

The model of *Health Links* has always been envisioned as part of the continuum of care and will be realized through implementation of the *Care Connections* plan. The formation and development of these models will match the unique needs of the population living across NSM's geographic areas, and will ensure the appropriate level of care and providers are integrated to ensure the goal of *Health Links* is achieved.

Excellent Care

French Language Services

The LHSIA states LHINs should..."*focus on French-speaking people as priority populations... the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario and respect the requirements of the French Language Services Act in serving Ontario's French-speaking community.*"

Excellent care in the NSM LHIN includes access and accessibility to services and program delivery in French.

Photograph courtesy of:
Royal Victoria Regional Health Centre

The planning and implementation of French language services is administered by the twelve *Care Connections* areas of focus. In NSM the French Language Health Planning Entity #4 plays a notable role in addressing the needs of the Francophone community. By advising the LHIN on how best to overcome existing barriers and how to improve access and accessibility to French language services, Entity #4 is helping to ensure the delivery of excellent care. Through the course of IHSP 2013 – 2016, Entity #4 will continue tobuild on and improve the current Joint Action Plan and the outlined deliverables that align with the needs of Francophones living in NSM.

Community Resilience and Capacity

> Excellent care for NSM residents can be achieved by the local health system partners in each of the LHINs five local geographic areas coming together collectively and collaboratively to improve capacity and resilience at the community level. This will serve to sustain and meet the needs of the local population, now and in the future.

Strengthening partnerships across the continuum of collaboration (Figure 4.1), to create efficiencies in delivering better care close to home, focuses on the needs of the population today but drives to achieve sustainable care for future generations.

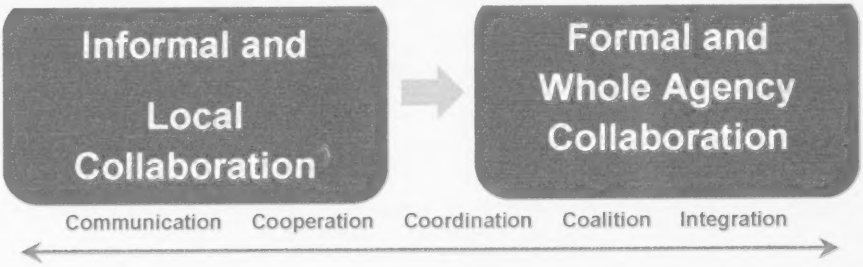


Figure 4.1: Continuum of Collaboration

Health System Funding Reform

The new Patient Based Funding (PBF) approach was introduced effective April 1, 2012 and has two components: the Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBPs). HBAM is an allocation model and management tool that uses demographic, clinical and financial information to estimate expected volumes of patients and costs at a facility level; this is then used to identify an organization's expected share of overall sector funding.

QBP's are targeted activities funded on a "price X volume" basis. They are funded based on evidence (e.g. utilization patterns, best practices) to encourage improvement in value for money, including improved outcomes and reduced variation across providers. Innovative solutions and approaches to new structures, models of care, funding, and resources to support system-wide and local improvements have to be integrated into the work of *Care Connections* moving forward.

Capital Planning

When it comes to delivering quality care to the residents of NSM, the unpredictable nature of the current economy and fiscal reality is a key factor that drives health system partners to collaborate and strategically think in new and innovative ways. As program and service delivery continues to transform into one system, the infrastructure needed to support models of care must also be considered within the planning equation.

Capital planning is guided by a Ministry–LHIN Capital Planning process and the awareness of health service providers to this process individually and collectively by working together with the LHIN and Health Capital Investment Branch for support, approvals and planning is crucial. Infrastructure planning for future population needs rests with the built environment of today. Innovative solutions and approaches to new structures, models of care, funding, and resources to support system-wide and local improvements have to be integrated into the work of *Care Connections* moving forward.

Integration

Ontario's Action Plan for Health Care outlines the vision of an integrated health system, for which the LHINs play a critical role in regard to implementation. Carefully planned coordination of health services and close collaboration among health system partners are critical to making the experience of care more seamless and easier to navigate so that people who require health care get the care they need, when they need it and as close to home as possible.

The NSM LHIN's community engagement and communications activities have recognized that integration means different things to different stakeholders, and acknowledge that sectors and communities will be at different stages in their awareness, understanding and commitment to change. Boards of Directors, in particular, play a key role in health system integration. With responsibility for strategic direction, finances, quality and safety, and performance of their organizations, Board leadership will prove critical moving forward.

Shared Governance

Health system transformation will require Board Governors from across the system in NSM to collaborate. New conversations to define more formal whole agency collaboration and system-wide shared governance opportunities will be of priority amongst service providers, both at the local community and system-wide levels (Figure 4.1). Organizational accountability, along with system level accountability will be explored and understood as the performance outcomes are established for system integration, in order to achieve the vision. Generative pro-active thinking and system re-engineering is enabling dialogue to move to a level where the role of shared governance can be collectively explored.

Evolving conversations to system level accountability, allows governors to envision better care and experiences for our residents by making the linkage between the quality and cost of their care, now and in the future. Sharing the gains and making strategic re-investments collaboratively is paramount in re-engineering a system that will improve the quality of care our residents deserve and expect.

Quality Improvement

People living in the NSM LHIN share the common vision of a high-performance health system; a publicly funded system that is accessible, effective, safe, person-centred, equitable, efficient, appropriately resourced, integrated and focused on population health. Such are the nine attributes of a high-quality health system identified by Health Quality Ontario (Figure 4.2). Present day capacity - building work being conducted in partnership with HQO will continue throughout the duration of IHSP 2013 – 2016. The NSM LHIN is committed to the application of quality improvement science to achieve its strategic objectives as identified through *Care Connections*. The organization is a leader in establishing a culture of continuous quality improvement using structured

Figure 4.2: Health Quality Ontario's Nine Attributes of Quality

improvement methods and models, including the Model for Improvement, Six Sigma and Lean.

Communications and Community Engagement

Open and effective communication and community engagement between the NSM LHIN, health system partners and residents of NSM, in addition to a host of additional stakeholders, is essential if an integrated health system is to develop and sustain itself. It forms the basis of lasting and meaningful relationships that are first and foremost based on mutual respect and trust.

While the role of the Communications Council within the *Care Connections* framework is to provide strategic communication and community engagement counsel and/or recommendations to the *Care Connections* Councils and their corresponding Project Steering Committees, the value this discipline brings to IHSP 2013- 2016 will be in its ability to sustain and build on the significant progress aready made regarding open and effective communication.

Each *Care Connections* Council is provided with communications support drawn from partners across the NSM LHIN. These supports report through the Communications Council whose role has been to develop a comprehensive strategy designed to promote and increase awareness of *Care Connections*, its concepts and successes both internally among health service providers/system partners and externally to the public.

Understanding that individual impact more often than not results in system impact, the Communications Council will continue to promote collaboration, knowledge exchange and information sharing in an effort to further support the vision of the NSM LHIN and basis of IHSP 2013 – 2016.

Project Management

Project management is the discipline of planning, organizing, securing, managing, leading, and controlling resources to achieve specific goals.

In Ontario, a common vision of clinical programs, access to care and electronic access to all health records is shared. In order to achieve the common vision, health care leaders recognize the importance of establishing a sound project management framework and Project Management Offices (PMO) across the province.

The NSM LHIN is committed to project management and has developed free LHIN-wide monthly training sessions for all health service providers in using project management tools. This ongoing activity was started in early 2011 and has now transformed the culture of managing projects in a healthcare environment. All twelve Chairs of the *Care Connections* Councils have been trained and are using a common tool to manage their projects, allowing contributing providers to see and report on progress within *Care Connections* projects.

section 5 | strategic priorities and directions for local health system

As an individual requiring care...

> *"A well-integrated health care system means the process makes sense to you. It gives you confidence that all the providers you interact with are complementing each other's efforts, are respectful of each other's contributions, and are working together in your best interest."*
>
> *- The Change Foundation, 2010*

The NSM LHIN Leadership Council is the Steering Committee for *Care Connections* and provides strategic advice to the NSM LHIN Chief Executive Officer (CEO) on issues related to the design and realization of an integrated health system.

The NSM LHIN Leadership Council is made up of system-wide leaders from across the continuum of care, the various geographic areas in North Simcoe Muskoka and various populations and sectors that encompass the health system including members of

Aboriginal and Francophone populations, community care, acute and primary care, municipal government, long-term care and health care professionals.

In the fall of 2012, the NSM LHIN Leadership Council strategically outlined the gains made through the committed work efforts and leadership of the twelve Coordinating Councils, and advised where focus should be given over the next three years.

The *Care Connections* twelve areas of focus remain the priority for IHSP 2013 – 2016. By extension, the recommendations and deliverables established and put forward by the twelve Coordinating Councils will be the priorities for change. Staying the course allows gains from the first two years of implementation to be sustained. A renewed focus on routine, rigor and discipline helps to build on these gains; to accomplish additional achievements in pursuit of NSM LHIN's vision of an integrated health system.

The following pages outline the purpose, strategic aims and goals of each of the twelve Care Connections areas of focus for the duration of IHSP 2013 – 2016, the projected final completion of each goal (100 % complete), and how the NSM LHIN intends to approach the need to measure outcomes. The projected completion demonstrates when the goal / project will be completed in its entirety with much of the implementation currently underway and continued deliverables to be achieved over 2013/14 and 2014/15 until final completion. Detail of the work to be completed over the next three years will be outlined in the North Simcoe Muskoka LHIN Annual Business Plan for 2013/14.

Family and primary health care will have more prominence in the local health system. It is a system that will require integration of strategic planning and implementation of primary care into each of the twelve areas of focus to ensure accountability for the complete journey of the person across the continuum of care. People across NSM share the common vision of a high-performing health system. Based on HQO's nine attributes of quality, person-centred care is the heart of why change is required.

Care Connections 12 Areas of Focus

Complex & Chronic Health Needs Coordinating Council

Purpose: To design and implement a comprehensive Complex & Chronic Health Needs Care System for the residents of North Simcoe Muskoka.

Strategic Aims: For persons living with complex & chronic health conditions...

1. **Person-Centredness:** improve person-centred care.
2. **Access:** improve access to care.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Complex Continuing Care: All residents of North Simcoe Muskoka receive quality Complex Continuing Care appropriate to their needs, supported by a model of care with a person-centred approach for people with complex and chronic health needs.	100% *		
Behavioural Support System: A LHIN-wide Behavioural Support System model is implemented to better care for this specialized population.	100%		
Chronic Disease Prevention and Management: To implement a LHIN-wide model for Chronic Disease Prevention & Management by supporting LHIN-wide and provincial initiatives.			100%
Cancer Care: To develop a LHIN-wide plan with recommendations for cancer services in NSM LHIN.		100%	

**Except 50% of evaluation of Physician & Nurse Practitioner Model in 14/15.*

In Home & Community Capacity Coordinating Council

Purpose: To support, sustain and expand in-home and community capacity to ensure that clients have timely access to the most appropriate level of care for their need; and, to ensure a LHIN-wide Seniors' Care Strategy is in place that encourages and promotes the wellness and independence of older Ontarians.

Strategic Aims:

1. Access: To build and leverage in-home and community capacity to support individuals and caregivers to live at home independently and safely as long as possible.
2. Integration: To ensure individuals have access to and receive care in the most appropriate location provided by the most appropriate caregiver.
3. Person-Centeredness: To strive to ensure satisfaction with care experiences for people using in home and community capacity and their caregivers.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Community Capacity Steering Committee: To coordinate the design and implementation of a LHIN-wide In-Home & Community Capacity Strategy.			75%
Seniors' Care Strategy Steering Committee: To coordinate the design and implementation of a LHIN-wide Seniors' Care Strategy.			75%

** This work will extend into the next IHSP.*

Maternal, Newborn, Child & Youth Health Coordinating Council

Purpose: To design, implement and provide leadership in advancing the care and service delivery models for the maternal, newborn, child and youth populations in NSM LHIN.

Strategic Aims:

1. Safety, 2. Population Health

To improve effectiveness in obstetrics and paediatrics standards of clinical processes and frameworks across the acute care system within the next three years.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Standardization: Implement standardization of Maternal Newborn Child and Youth work across the acute care settings.			100%
Maternal Mental Health: Implement a pre/post natal standardized program for mothers with mental health disorders (e.g., mood disorders, depression, substance abuse).		100%	
Collaboration: Establish a Community Practice for all NSM Maternal Newborn Child and Youth work.			100%
Developmental Services: Establish a relationship between developmental services, mental health and children.			100%

Medicine Coordinating Council

Purpose: To work collaboratively to facilitate implementation of the planning and design work completed by the Medicine group of the NSM LHIN's Care Connections project. The goal is to improve the care and health outcomes for individuals requiring critical care services, emergency department services or, integrated vascular and/or stroke healthcare.

Strategic Aims:

1. Access, 2. Efficiency, 3. Safety

To provide timely, equitable access to medicine services with optimal outcomes for all in the North Simcoe Muskoka LHIN.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Critical Care: Build the foundation to develop and sustain an integrated critical care system across the LHIN that is aligned with and guided by the Critical Care Secretariat strategic initiatives and NSM LHIN.			100%
Integrated Vascular: Develop a comprehensive integrated vascular program aligned with the Ontario Integrated Vascular Health Strategy, and implement recommendations of the NSM LHIN Integrated Vascular Steering Committee (i.e. stroke rehabilitation).			100%
Emergency Department: Develop an emergency medical system which supports quality care of patients and where staff is aligned with Emergency Department LHIN Lead strategic and provincial initiatives, and plan, implement and evaluate the wait times in emergency department by CTAS levels, time- to physician initial assessment and admits to an in-patient unit.			100%

Mental Health & Addictions Coordinating Council

Purpose: To improve the care for individuals living with mental health and addictions conditions, thereby optimizing their health and well-being.

Strategic Aims:

1. Access: To enhance the accessibility of mental health and addictions programs and services.
2. Appropriate Resourcing: To ensure mental health and addictions programs and services are appropriately resourced and integrated.
3. Equity: To ensure equitable, safe, timely access to a single regional system of high quality, person-centred acute care services delivered across three sites and fully integrated within the broader continuum of care.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Acute Mental Health Schedule 1 Beds: To build a regional system of acute MH care through the redistribution of Schedule 1 Beds for the NSM LHIN, (Of the 31 beds from Way-point Centre for Mental Health Care, 11 have moved to Royal Victoria Regional Health Centre and 20 will move to Georgian Bay General Hospital).		100%	
Building Child & Adolescent Capacity: To build child and adolescent mental health capac-ity in the NSM LHIN.		100%	
Community Crisis Management: To enhance crisis management and community resources for mental health and addictions for the NSM LHIN.		100%	

Surgery Coordinating Council

Purpose: To improve the surgical care for individuals living in North Simcoe Muskoka through the implementation of a comprehensive, coordinated and integrated surgical programs.

Strategic Aims:

1. Efficiency, 2. Effectiveness, 3. Access

To provide timely, equitable access to orthopaedic care with optimal outcomes for all in the North Simcoe Muskoka LHIN.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Musculoskeletal: Implementation of a LHIN-wide Musculoskeletal Program.			100%
Plastic Surgery: Development and implementation of a LHIN-wide Plastic Surgery service.			100%

Communications & Community Engagement Coordinating Council

Purpose: To provide strategic communication and community engagement counsel and recommendations to the Care Connections Coordinating Councils and their corresponding Project Steering Committees.

Strategic Aims:

1. Effectiveness: To increase public awareness of Care Connections its concepts through media or other communication mechanisms
2. Effectiveness: To increase public knowledge of health information and services.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Develop an overarching Care Connections Communication and Community Engagement Plan with an evaluation component in order to sustain the plan for the future.	100%		

eHealth Coordinating Council

Purpose: To support the development of an integrated electronic system of health services that provides person-centred, timely, equitable access, high quality, evidence-based services in an efficient, effective and sustainable manner.

Strategic Aims:

1. Efficiency: To provide strategic direction on all eHealth projects and initiatives within the LHIN.
2. Integration: To provide oversight for the project planning and implementation of all Provincial and six LHIN cluster level eHealth projects.
3. Access: To act as the LHIN-wide Steering Committee on all eHealth projects where direct LHIN-level project management is required.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Collaborative Change: To assess readiness and conduct collaborative project management in order to effectively champion change for the implementation of provincial and local information management projects.			100%
Continuous Improvement: To monitor and evaluate the implementation and outcomes for the sustainability of the information management projects: • Improved integration and transitions of care • Quality improvement and better health outcomes • Sustainable financial performance and accountability • Improve system access and capacity.			100%
Capacity Building: To share knowledge, educate and develop awareness of health information management.			100%
Standardization: To subscribe and adhere to a set of standards, policies and processes as established by Canada Health Info-Way and supported by the Council.			100%

Transportation Coordinating Council

Purpose: To identify transportation requirements and establish an integrated transportation system in alignment with alternative technologies and service delivery options to improve health outcomes and wellness services.

Strategic Aims:

1. Access: To enable inter-facility transportation system that is user-friendly, standardized and time-sensitive.
2. Safety: To provide a system that matches the transportation service to the clinical needs of the patient / individual.
3. Efficiency: To provide a coordinated system that facilitates the optimal use of resources in patient / client movement.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Inter-facility Transportation: To focus on inter-facility transportation requirements for patients in hospitals and clients served in long-term care homes. The populations identified in this focus area include: • Individuals of all age groups receiving health care services in hospital settings • Frail seniors and/or individuals possessing a high level of care acuity receiving health care services in long-term care homes.		100%	
Community Transportation: To focus on community transportation requirements clients living in the community who require transportation to access health care services. These clients may have limited transportation access due to physical, mental or financial disability or live within isolated geographic locations. The populations identified within this focus area include: • Disabled Adults, Able-bodied Adults, Family and Youth, Frail Seniors.		100%	

Governance Coordinating Council

Purpose: To provide leadership in the transformation of the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) system of governance from an individual, provider-centric model to a person-centred model of collaborative governance characterized by health system and population health-based decision-making.

Strategic Aims:

Integrated: To increase the capacity of health service provider Boards to fulfill their governance mandates and responsibilities as set out in the Local Health System Integration Act (2006).

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Oversee the development of a new governance model for the health system. Elements of the new governance model will include communication framework, delegation of authority mechanism, tools to support Board and adoption of current/future legislative requirements.			100%
Oversee the development of a governance education plan for the health system.			100%

Integrated Health Human Resources Coordinating Council

Purpose: To create a health human resources strategy for North Simcoe Muskoka and provide strategic health human resources advice that informs decisions and enables system change.

Strategic Aims:

1. Appropriate Resource: To improve resource allocation for people working in all sectors in North Simcoe Muskoka.
2. Equity: To improve equity for people working in all sectors in North Simcoe Muskoka.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
To create a ten year health human resources strategy.	100%		
To develop a LHIN-wide recruitment portal.	100%		
To develop workforce planning database.	100%		
To collaborate with unions to develop workplace mobility strategy.		75%	100%

System Navigation Coordinating Council

Purpose: To improve the experience of each patient/caregiver and helps ensure the right care at the right time in the right place. It includes information and knowledge sharing, assessment and the development of a shared plan of care, linkages to appropriate services or place of care and appropriate follow-up to ensure a safe referral or transition. All populations benefit.

Strategic Aims:

1. **Person-Centredness:** To develop a comprehensive and current system-wide inventory of health and social services.
2. **Access:** To develop a user-friendly and standardized referral system to match client / individual need to available resources.
3. **Safety:** To develop LHIN-wide protocols to standardize client / individual transitions from one setting / sector to the next.

Goals - Project Steering Committee(s)	Projected Completion		
	2013/14	2014/15	2015/16
Information and Referral: To guide the development of information and referral services in North Simcoe Muskoka in a strategic and coordinated manner and to provide a comprehensive continuum of service to a wide range of stakeholders including: • Individuals of all ages requiring health-related information and services • Population-specific requirements considered (Aboriginal, Francophone, Mental Health and Addictions) • Health service providers and agencies.		100%	
Transition to Care: To coordinate a systems approach in North Simcoe Muskoka that supports clients / individuals as they transition from one care location to another. Access to a safe and coordinated transition is an important function within the health system and it is a key enabler supporting clients / individuals to remain safely in the community minimizing readmission to hospital (i.e. aligned with bestPATH): • Individuals with complex needs who experience frequent transitions between service providers • Individuals who are not connected to a primary care practitioner / provider • Seniors and individuals living with mental health and addiction issues.			75% *

* *This work will extend into the next IHSP.*

Measuring Outcomes

Across the NSM LHIN, be it individually, organizationally or collectively, there is a desire to achieve high standards and to ensure the needs of communities are being met in the most effective way. As public stewards of the local health system, the NSM LHIN is committed to demonstrating outcomes and/or success through clear measures linked to its strategic direction and priorities. IHSP 2013 – 2016 builds upon the performance management approach introduced in IHSP 2010 – 2013; an approach predicated on 5 principles which guide the development of a core group of indicators, specific timelines and clear accountability.

Alignment

All performance measurements should have coherent flows of logic from strategic areas of focus through to service-level performance measures and targets. In addition, and as demonstrated in Figure 5.1, the performance management approach at NSM LHIN aligns not only with the mission and vision but also three widely accepted approaches to demonstrating value and managing performance.

The Triple Aim Framework

Developed by the Institute for Healthcare Improvement, a not-for-profit organization in Cambridge, Massachusetts, this Framework describes an approach to optimizing health system performance.

> The "Triple Aim" strives to improve three things for a population simultaneously: (1) peoples' health care experiences (2) the health of populations; and (3) per capita cost of health care. NSM LHIN has translated these and aligned them to its mission of "Together Achieving... Better Health. Better Care. Better Value."

The Balanced Scorecard

At the highest level, the Balanced Scorecard framework

Figure 5.1: Care Connections Performance Cascade

(Kaplan and Norton, 1992) helps organizations put strategy at the centre of the organization by translating strategy into operational objectives that drive both behavior and performance.

Although many organizations already use a collection of financial and nonfinancial (e.g. clinical) measures of performance, a well-designed balanced scorecard is different because it uses the four perspectives or domains to form a chain of cause-and-effect relationships. Effectively, this chain of relationships helps identify how the results being monitored in each domain are contributing to the achievement of the organization's strategy.

The Nine Attributes of Quality

Health Quality Ontario (HQO) publishes annual reports on Ontario's Health Care System which identify nine attributes of a high performing health system (Figure 4.2); a system that is accessible, effective, safe, person-centred, equitable, efficient, appropriately resourced, integrated and focused on population health.

Consistency

Performance measurement should take a uniform approach across the NSM LHIN, at different levels of the system, and across different types of providers. With system-wide *Care Connections* Councils and Project Steering Committees being composed of interdisciplinary and cross-sector representatives, a consistent approach will allow all organizations to benefit from a clearer understanding of requirements and expectations.

Transparency

By establishing clear and pre-determined performance measures and interventions, health service providers can assure NSM communities and other stakeholders that there is a focus on achieving the goal of a high quality health care system.

Minimize Collection Burden

The NSM LHIN recognizes the administrative burden created when additional performance monitoring is a requirement. In order to maximize value and ensure that resources are not unnecessarily allocated to administrative activities, attempts have been made to minimize the burden of the collection of data and information by using existing indicators and sources of data where possible.

Ownership

By ensuring performance indicators are developed and/or adopted by the *Care Connections* Councils and Project Steering Committees, the NSM LHIN is encouraging the ownership of results. Measurable, outcome-based results will provide evidence needed to monitor and report on the success of any transformation and integration initiative.

All of the *Care Connections* Councils have been introduced to the "Model for Improvement" (Figure 5.2) developed by the Institute for Healthcare Improvement to assist in establishing their performance indicators.

The model says that, in order to succeed, quality improvement projects should have a clear aim and track specific measures that demonstrate whether specific changes lead to an improvement. This provides solid evidence to other organizations when they are looking for ways to improve quality.

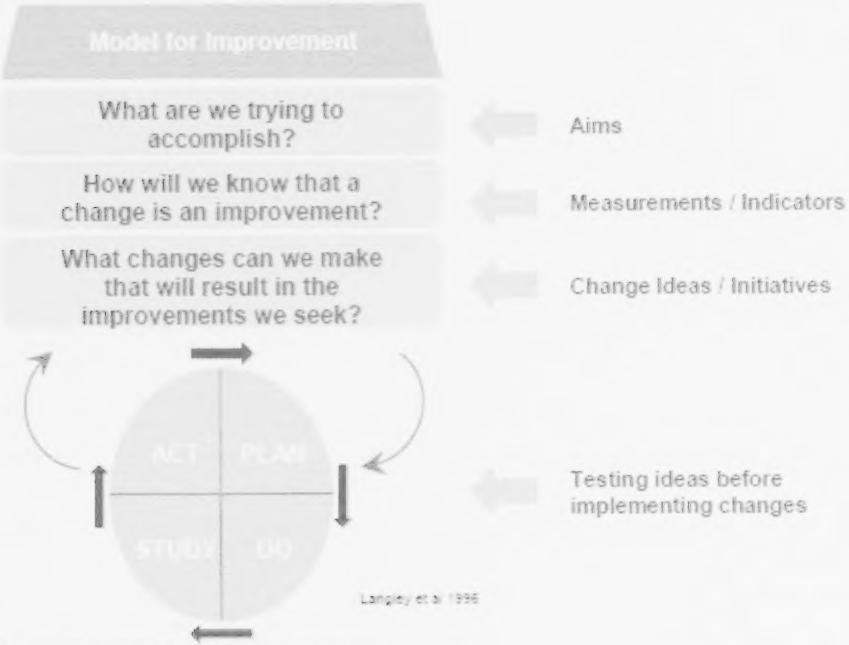

Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What changes can we make that will result in the improvements we seek?
Aims
Measurements / Indicators
Change Ideas / Initiatives
ACT
PLAN
STUDY
DO
Testing ideas before implementing changes
Langley et al. 1996

Figure 5.2: IHI Model for Improvement

section 6 | conclusion

IHSP 2013 – 2016 has evolved from a simple but critically important premise: that residents and health system partners alike share a common belief in both the importance of the health system and its responsiveness to the needs of local communities. Aligned with ministerial priorities and pan-LHIN system imperatives, IHSP 2013 – 2016 has adopted the NSM LHIN's vision, its *Care Connections* framework and inspirational values. As a result, long-term sustainable change, that is to say a new way of thinking, acting and behaving, will be attained.

The health system in NSM has much to celebrate. The resilience and capacity of health system partners at the system-wide and local levels to deal with and effectively manage change through continuous improvement, is a foundation upon which future change and opportunities will be based.

The reality of health system partners taking ownership, accepting accountability and managing transformation across the NSM LHIN cannot be understated and, as a result, by remaining focused and committed to a common vision, they can continue to enhance the health of NSM's population through better health, better care and better value.

The NSM LHIN landscape is changing and there is still much to be done. Ontario's population is aging; more so across NSM. As people age, they require more health care; more often than not, more complex health care. With the complexity of the residents' health needs increasing, so too must the capacity and efficiencies of service and program delivery be enhanced in order to provide quality care that is accessible and safe within community, in a manner that is integrated and appropriately resourced within the local health system. This ever-changing landscape and environment requires a nimble and adaptable local health system that is ready to embrace change in order to support its mission, vision and values especially as they relate to primary care and the building of healthy communities.

Through IHSP 2013-2016 and *Care Connections*, there are many new and exciting opportunities to be realized over the next three years, the likes of which are only just now beginning to align with and support health system transformation across the NSM LHIN.

Committed to holding the gains, IHSP 2013 – 2016 stays the course through a renewed affirmation of basic tenets including a collective will to change, a focus on what can be controlled, careful attention to the changing landscape, open and honest dialogue, the courage to take risk, an awareness of organizational readiness and capacity, and a realization that our relationships are very much interdependent. All in continued pursuit of...

Healthy People. Excellent Care. One System.

references / appendices

References

1 - IHSP Page 5 | Estimates, 2011/12
2 - IHSP Page 6 | 2012 Ontario Provincial Budget, p. 23
3 - IHSP Page 6 | Ontario's Action Plan for Health Care, p. 7
4 - IHSP Page 6 | Ontario's Action Plan for Health Care, p. 7
5 - IHSP Page 6 | Ontario's Action Plan for Health Care, p. 6
6 - IHSP Page 7 | Ministry presentation to Primary Care Leads Jan 2012/Baker report
7 - IHSP Page 10 | 2012 Ontario Provincial Budget, p. 28

Appendices

Appendix A NSM LHIN Environmental Scan
Appendix B IHSP Common Environmental Scan
Appendix C Planning Framework

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